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ABSTRACT

Most physicians can expect to counsel a family or individual concerned about possible exposure to acquired immue deficiency syndrome (AIDS). Medical professionals need comprehensive AIDS training and educational programs which cover medical, epidemiologic, psychosocial, and neuropsychiatric aspects of AIDS. Counseling psychologists can provide a unique perspective and service in training health care professionals in the prevention and intervention of AIDS by helping them acquire or alter personal-social skills, improve adaptability to changing life demands, enhance environmental coping skills, and develop a variety of problem-solving and decision-making capabilities. Counseling psychologists can help medical personnel develop the counseling skills they need to support the patient and family and to help them make appropriate decisions, adjustments, and changes in behavior necessary to cope with the impact of AIDS. Not only can counseling psychologists train medical personnel to positively impact AIDS patients, they can also impact hospital policies which adversely affect AIDS patients. By training medical personnel to enhance healthful behavior patterns through the development of interpersonal and counseling skills, attitude change, and a reduction in discomfort and conflict which may interfere with quality patient care, counseling psychologists can greatly impact the AIDS crisis. (NB)

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TRAINING MEDICAL PROFESSIONALS IN THE PREVENTION AND INTERVENTION OF AIDS

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Paper presented at the Annual Convention of the American Psychological Association, 95th, New York, NY, August 28-September 1, 1987.

AIDS: A Challenge to Counseling Psychologists

TRAINING MEDICAL PROFESSIONALS IN THE PREVENTION AND INTERVENTION OF AIDS

Medical professionals need comprehensive AIDS training and educational programs which cover medical, epidemiologic, psychosocial, and neuropsychiatric aspects of AIDS. Counseling psychologists can provide, within such programs a unique perspective and service in training healthcare professionals in the prevention and intervention of AIDS.

Paraphrasing a July 1987 publication of the American Medical Association: Most physicians can expect to counsel a family or individual concerned about possible exposure to HIV and to be questioned as to the meaning of a positive HIV blood test. They are likely to have a counsel and monitor seropositive individuals for prolonged periods. For those individuals who develop Aids Related Complex or full blown AIDS, the impact of the disease goes far beyond the immediate medical issures. The costs of care are enormous. The psychological impact of HIV infection upon patients, families, and coworkers can be equally enormous. The physician must be aware of needs for counseling and support in all forms. This effort, in addition to managing a complex clinical problem can be time consuming, demanding, and debilitating to the physician. Furthermore, physicians are expected to help educate the public in the prevention of this disease. The prevention of spread of the virus must rely on education of the public to reduce risk. Therefore, the major goal of education should be to reduce spread by sexual contact or intravenous drug abuse - the two most common modes of transmission. The behavioral change that is necessary to reduce high risk activities will be difficult to achieve and will be controversial, since human sexuality

CG 020415

and chemical addiction are involved. Although such statements and goals are laudable, the AMA publication does not address where or how the physician - or any other medical professional, is to develop the skills and attitudes, needed to address these areas. As counseling psychologists, our services are intended to help persons acquire or alter personal-social skills, improve adaptability to changing life demands, enhance environmental coping skills, and develop a variety of problem-solving and decision-making capabilities. These skills must be built by the medical professional if s/he is to become truly competent and succeed at the tasks implied by the AMA's publication.

Counseling psychologists' services should facilitate effective functioning during the lifespan developmental process and emphasize positive aspects of growth and adjustment. When such services are aimed at professional training, it becomes particularly important to provide opportunity to discuss emotional reactions to working with HIV infected people and to develop sensitivity to the special needs of persons in high risk groups.

Specifically, in medical settings, counseling psychologists are often employed to help others negotiate what is referred to as the "psychosocial world of the patient" - that is, all aspects of the patient's culture, daily life activities, cognitive difficulties inlearning self-treatment techniques, patients' attitudes and motivational which may be life-enhancing or exacerbating illness and distress. We, by the nature of our basic training and skills, can readily educate other medical professionals in these areas.

AIDS fosters the occurrence of critical and nonormative life events - including illness and threatened illness, loss of employment and support systems, and the unexpected death of a spouse. Such events may interrupt the functioning of an individual and his/her family. Most physicians and medical educators want to learn counseling skills so that they do not inadvertently exacerbate the illness, adding stress by their own statements and manner or lack thereof. They wish to support the patient and family, help them make appropriate decisions, adjustments, and changes in behavior necessary to cope with the impact of AIDS - from prevention, to living with seropositivity, to ARC, to AIDS. The lifespan orientation of counseling psychologists', our expertise in interpersonal skills, sensitivity to cultural differences and expertise in producing behavioral change, in my opinion, places counseling psychologists in an integral position to meet such primary goals of medical education.

As we train others to positively impact patients and their families during periods of illness, grief, and loss related to AIDS, ARC, and changes in lifestyle necessitated by the threat of that disease, we can also impact hospital policies which adversely effect patients. For example, most hospitals only permit immediate family members to visit patients in critical or intensive care units and expect those same individuals to make medically informed decisions that would, presumably, reflect the patient's own wishes. Partners, lovers, spouses - be they the same sex or opposite sex, are often denied visitation and input into decisions at these crucial times. If that individual is not on the best of terms with the recognized family - or if there is no family, the institutional policies and medical professionals own judgements will prevail regarding treatment. The challenge here to is train the medical professional to become patient advocates who act in the best interest of the

individual. Advocacy can occur as a prevention or intervention. For example, prevention in the case cited above would involve first educating the physician in matters such as power of attorney, durable power of attorney, and living wills. The second step would call for the physician, nurse-practitioner, and so one, to educate the patient regarding these documents purpose and necessity, as well as resources for obtaining them. This task presupposes a reasonable ability to comfortably and openly discuss issues such as quality of life, loss of ability to work, fears about dying, trust, and caring, sexuality to name just a few.

Yet, medical professionals are people like any other people. They have backgrounds, histories, experiences, fears, and personal values like anybody else which they cannot magically put aside. They must become self-aware, confront their own "isms" and biases which may be obstacles to the provision of quality patient care. Counseling psychologists' interactions with professionals-to-be in the classroom, and both formal and informal instructional and consultative contacts with those in training and practicing can aid that process.

How many of us have ever taken a close look at the task facing the physician when s/he first meets an AIDS, ARC, HIV+ "at risk" or "worried well" individual? Typically, the physician is seeing a relatively young, healthy - or until very recently, someone who was a healthy person. If the physician is young, has children, or grandchildren, or someone close to them who resembles this individual, the physician may feel very threatened at this point in the meeting. The physician may block this response through denial or developing what appears to the patient as a callous and intimidating manner. Yet, most physicians would

prefer to relate to patients in such a way as to invite cooperation and reduce hostility. They want to engender an atmosphere which promotes the patients' disclosure of important information needed for accurate diagnosis, rather than an environment in which the patient may be frightened, ashamed, and withholding.

No matter how the initial greeting goes, the physician must set the patient at ease, develop rapport with the patient, obtain a complete history in a nonjudgemental fashion which is inclusive of a sexual history and drug history, conduct a physical examination, and be able to answer questions and counsel patients appropriately regarding treatment options, laboratory tests, including HIV screening in asympotmatic patients, safer sex practices, family (pregnancy) planning, and treatment in the case of the AIDS patients. Although these tasks may not sound difficult to the well-trained, and well-informed amongst us, most medical training programs do not instill the attitudes and interview skills needed to perform those tasks in a way which is satisfying to both the patient and physician.

Within most medical school curriculum, the management of opportunistic infections is typically well covered. Yet, 10% of AIDS cases present with neuropsychiatric symptomatology! It is not beyond the scope of CP to teach physicians, physician assitants, nurse practitioners and the like, to recognize the symptoms and work-up a patient accordingly. Naturally, it is then necessary to teach those professionals when and how to make a referral for further psychological, neorological, or psychiatric evaluation. And, then the CP may also train the provider to present findings and rationale for consultations to patients in such a manner that the healthcare provider does not overwhelm the patient with information, nor deceive the patient, and permits the patient to openly express his|her feelings.

The ability to openly express one's feelings to healthcare workers is, as most CP's are aware, partly a reflection of the comfort and trust which exists between the parties. It has historically been counseling psychologists who have not only examined the qualities which enhance therapeutic relationships, but have also offered psychoeducational programs to train others in "awareness of differences." Attitudinal change is necessary for many health care professionals, For they, like so many others, may be ignorant of cultural differences, homophobic, or racist. For example, in our community, a family physician approached me to consult on a AIDS patient who happened to be Mexican-American. The physician wanted me to talk to the patient about his homosexuality and convince the patient to tell his only surviving family member - his mother, about his homosexuality and his disease. The physician was stymied - he could not understand why a young man who might die in a relatively short time, did not want his mother to know what was wrong nor did the patient appear to want his mother's support. The physician felt the patient should "somehow make peace with his mother." While this physician's heart may have been in the right place, his ignorance of Hispanic cultural mores was apparent. On another occassion, one of my colleagues was attending morning rounds with our family practice residents and several community physicians. One resident was particularly perturbed that morning because of phone calls received overnight from a patient, recently discharged after a bout with pneumocistis. It seemed the patient called when his resident physician was on-duty, and routinely asked for enema prescriptions. The patient, during his hospitalization, was told that he had AIDS and that his sexual habits must be changed. Rather than look at his requests as potentially related to attempts to comply with his physician's suggestions, the staff physicain stated,

"Tell him to have his boyfriend stick it somewhere else." The resident who cares for this patient laughed at the comment and took offense at my colleague's suggestion of support for the patient. Later that day, I had the opportunity to meet with the resident. I brought up the incident just described. ALthough initially defensive, the resident could understand that the patient was reaching out to him for help, and, whether appropriate or not, may have been trying to comply with the physician's suggestion that he engage in safer sexual practices. We discussed the patient's potential need for new forms of sexual arousal and practice, and anger at the medical system which is unable to make him well again, being directed at his physician. The resident then brought up his own concerns about working with AIDS paitents in general and his discomfort with gay men in particular. Gradually, the resident developed his ability to discuss sexual practices of all kinds with various patients, improved communication with the patient in question, and has since also joined the L.A. Co. AIDS Task Force.

So far, I have tried to give examples of medical educators and professionals which must be engerdered within that group in order for medical professionals to effectively intervene and prevent AIDS. Along the way, I hope to have demonstrated that counseling psychologists are particularly well-suited to enable that process.

Initially, it was stated that medical professionals need a comprehensive training and education program which covers the multiple facets of AIDS. As counseling psychologists, we can educate those professionals regarding lifespan development and the impact of disease on the lifecycle; basic communication, interview, and counseling skills with special emphasis on taking a drug and sexual history;

self-awareness and attitude change especially as relates to homophobia, cultural differences, intra- and interpersonal conflicts about drug use and addiction and sexual practice; and patient education techniques. Opportunities exist for counseling psychologists to help define medical training programs' curricula, to develop in-service training programs for hospitals, and continuing education programs for healthcare providers. We can utilize both didactic and experential techniques to educate others. Curriculum changes in healthcare training programs, including medical schools, nursing programs, physical therapy, medical technology, and so forth, may necessitate faculty development. The counseling psychologist can utilize his/her skills to educate other teachers and educators. In practice settings, the counseling psychologist can directly supervise or consult on cases. We can also offer support groups for those professionals; through such groups, burn-out can not only be eased, but myths and biases can also be addressed.

If we can train medical professionals - physicians, nurses, social workers, and others, to enhance healthful behavior patterns by developing their interpersonal skills and counseling skills, changing attitudes, and reducing discomfort and conflict which may interfere with quality patient care, we, as counseling psychologists can greatly impact the AIDS crisis.